STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 13, 2017 through March 23, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 102. The Stage 2 survey sample was 23. Abbreviations/definitions used in this report are as follows: NHA- Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN- Registered Nurse; LPN- Licensed Practical Nurse; CNA- Certified Nurse's Aide; eMAR - electronic Medication Administration Record; FMD- Facility Maintenance Director; UM- Unit Manager; NP - Nurse Practitioner; MDS - Minimum Data Set/assessment tool used in long term care facilities; PU - Pressure Ulcer/sore - area of skin that develops when the blood supply to it is cut off due to pressure; NSS - Normal Saline Solution; CDD - clean dry dressing; eTAR - electronic Treatment Administration Record; N/O - New Order; BM/bm - bowel movement; BS- Blood sugar- amount of sugar or glucose in the blood;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 DTI (Deep Tissue Injury) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; sDTI-suspected DTI; MOM- Milk of Magnesia/liquid medication used for constipation; NN - Nurse's note; PPE - Personal Protective Equipment (mask, gown, gloves, etc.); PRN - as needed; Post-after; Pt. - patient; Q - every; SBP - Systolic Blood Pressure/the top number of the blood pressure reflects pressure in the blood vessels when the heart is beating; c - with; cm - centimeter, unit of length; med - medication; ml - milliliter; r/t - related to; Rt/R - right; Blanchable - skin loses redness with pressure; bilateral heels - both heels; C-diff - Clostridium difficile/bacterial overgrow that releases toxins that attack the lining of the intestines; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Constipation - difficulty in passing stool; Contact Precautions - procedures used to prevent transmission of infectious agents; Dementia - loss of mental functions such as memory and reasoning that is severe enough to	F 000		

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F 000	Continued From page 2 interfere with a person's daily functioning; Diabetes - Diabetes Mellitus-DM: more commonly referred to as "diabetes" - a chronic disease associated with abnormally high levels of the sugar glucose in the blood; dermatitis- inflammation of the skin; Dialysis- clinical purification of the blood as a substitute for the normal function of kidney; Dulcolax- medication given to stimulate a bowel movement; Dysphagia - difficulty swallowing; Epithelialization - formation of granulation tissue in an open wound; Erythema - a diffuse redness of the skin; Exudate - accumulation of fluids in a wound; Gluteal - pertaining to the buttock muscles or the buttocks; Granular/granulation - kind of tissue formed during wound healing, with a rough or irregular surface; Hand hygiene - referring to any method of hand cleansing; Hydrogel - wound treatment; incontinent- no control of urine; Ischial - bony areas on each buttock; Levemir Insulin- a long-acting Insulin used to control blood sugar; Neuropedic mattress-state of the art manufacturer of therapeutic pressure redistribution support surfaces; Non-blanchable - defined area of redness that does not become pale under applied light pressure; ORIF-Open Reduction Internal Fixation-surgical procedure; Pathogens- a bacterium, virus or other microorganism that can cause disease; Peri-wound - skin/tissue surrounding a wound; Shearing-friction exerted when a resident is	F 000		

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F 000	Continued From page 3 pulled in bed and the skin is compressed against the linens; RLE-right lower extremity; Sacrum - large triangular bone at base of spine; Serous - a thin, clear, light yellow watery fluid found in many body cavities; Serum filled blister - filled with clear fluid; skin prep.-liquid film-forming dressing that upon application to intact skin forms a protective film to help reduce friction during removal of tapes and films; Standard Precautions - a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes; Unstageable - Tissue loss in which actual depth of the pressure ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed). Braden scale-toll to determine the risk of PU; Zguard-medicated dressing treatment; Eschar-dead tissue that is brown or black; off loading- relieve pressure; Ativan medication for anxiety, nervousness; Barriatric-dealing with obesity; UTD-unable to be determined-can't measure how deep the wound is.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's	F 241		6/5/17

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F 241	Continued From page 4 individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one (R227) out of 23 Stage 2 sampled residents was treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. The facility failed to ensure that R227's call for assistance was honored, so that her needs were addressed in a timely manner. Findings include: R227 was observed on 3/14/17 at 2:00 PM in bed with her right leg in a brace. R227 was very pleasant and she answered questions appropriately. On 3/17/17 at 2:20 PM, R227 stated that on 2/27/17 around 7:30 pm, she used her call light to ask staff for her medication (Xanax) so she could get some sleep. After close to 30 minutes, R227 stated that E12 (CNA) came in, asked her what she needed and told her that she was not her nurse, but she would let R227's nurse know. E12 then turned off the call light and left. R227 stated after approximately 30 minutes, she turned on her call light again to ask about the medicine. E12 came in again, asked her what she needed, turned off the call light and told her she would let her nurse know. R227 stated that because nothing was happening, she repeated the action two more times, that is, turning her call light on, E12 coming in and turning the call light off, and saying her nurse had been notified. On the last (fourth) attempt, both her nurse (E13) and E12 came in to R227's room. R227 stated that E13 expressed disappointment in her for being upset	F 241	F241 Dignity and Respect of Individuality 1. R227 was not negatively impacted by this deficient practice. Medication was not due for administration. Resident did receive medication as ordered within specified Q8H PRN time frame. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. A root cause analysis was conducted and it was determined that nursing staff was turning off call bells PRIOR to residents' needs being met. Facility to create and implement a new call light response system called the NO PASS ZONE. The NO PASS ZONE procedure is that all staff answer call bells and all call bells are to be left ON until resident's need is met. Staff Educator/Designee to in-service all staff and nursing staff on leaving call bells on until resident's need is met. Staff educator to implement No Pass Zone into New Hire Orientation process for all new employees in order to maintain compliance. 4. Maintenance Director/Designee to conduct random call bell response times daily by turning on a call light and tracking how long it takes for staff to respond. Maintenance Director/Designee will audit daily until 100% compliance is met over 3	

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F 241	Continued From page 5 with him that she had not gotten her medication yet. R227 stated that E13 told her that E12 did not tell him about her asking for her medication, while E12 insisted she did. R227 indicated both staff were arguing about the issue, so, in tears, she kept pressing the call button to get the nurse in charge. R227 stated that E14 (charge nurse) came right away, tried to comfort her and ordered E12 and E13 to wait outside. After hearing R227's narrative, R227 stated that E14 reassured her she would take care of this. R227 stated that E13 came in after that with her medication. Review of R227's medical record revealed that one of the resident's admission diagnoses was anxiety disorder, for which the physician ordered Xanax to be provided three times a day, as needed. This finding was reviewed with E2 (DON) and E3 (ADON) on 3/23/17 at 3:30 pm.	F 241	consecutive days. Maintenance Director/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. Maintenance Director/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. Maintenance Director/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. Admissions Director/Designee to interview a random sample of three residents per day on whether or not their needs are met timely with call bell use. Interviews will be daily or until 100% compliance is reached for 3 consecutive days. Interviews will then be three times weekly or until 100% compliance is reached for three consecutive times. Interviews will continue at once per week until three consecutive weeks are 100% complaint. If a random sample of three resident interviews are 100% compliant in one month, the deficiency will be considered resolved. Results of interviews will be presented at QA committee meeting.	
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		6/5/17

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F 309	Continued From page 6 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of facility documentation, it was determined that for five (R28, R89, R102, R152, and R185) out of 23 Stage 2 sampled residents, the facility failed to ensure that each resident received and that the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. For R89, the facility	F 309	F309 Provide Care/Services for Highest Well Being 1a. R89 was not negatively impacted by this deficient practice. MD has made no changes to residents insulin regimen. 1b. R89 was not negatively impacted by this deficient practice. KUB results within normal limits. 2a. All diabetic residents have the	

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F 309	Continued From page 7 failed to notify the physician when blood glucose levels were above 250 according to physician's orders, and the facility failed to administer bowel medications according to physician's orders. For R28, the facility failed to follow a standing physician's order to initiate the Bowel Protocol. For R185, the facility failed to follow the physician ordered parameters to hold an anti-hypertensive [maintain normal blood pressure] medication when her SBP was less than 110 or her heart rate was less than 55. For R152, the facility incorrectly held Insulin 3 times when the residents BS's were in the 90's and there were no physician ordered parameters to hold the medication. Additionally, the facility administered a Dulcolax suppository when it was not indicated. For R102 The facility failed to ensure that R102 was free from open areas at pressure points such as sacral and left and right buttock during his short term stay or for 90 days in the facility. R102 was found with open areas on the left and right buttocks identified by the facility as Moisture Associated Skin Dermatitis (MASD), 7 days post admission to the facility. Findings include: The facility's Bowel Protocol, dated 4/2013, stated, "Residents will be monitored for bowel elimination so that timely interventions can be implemented to prevent potentially serious complications". The Procedure stated, "...3. Any resident who is identified as having gone 9 shifts without a BM has the Bowel protocol implemented...7-3 shift: MOM 30ml to be administered on the day shift following discovery that 9 shifts have passed without a BM. 3-11 shift: Dulcolax suppository PR [per rectum] to be given on the 3-11 shift following administration of MOM, if MOM has not been effective. 11-7 shift: If there are still no results by the following 11-7 shift, a	F 309	potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 2b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3a. Electronic health record corrected to include a section to document MD notification on the MAR. Staff educator/designee to educate nurses on following MD orders to notify when blood sugar is outside of parameters and to document in accordance with new EHR process. 3b. Unit Manager/Designee to audit vital sign report daily and indentify those residents who meet the bowel protocol criteria. Unit Manager/Designee to maintain daily BM List identifying those residents who should have the bowel protocol initiated that day. 4a. DON/Designee will audit diabetic MAR s to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting.	

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F 309	Continued From page 8 fleet's enema is to be given on the first med pass....5. Each portion of the protocol will be given and documented...6. Effectiveness of the protocol is communicated from shift to shift and documented in the medical record." 1A.Review of R89's clinical record revealed: R89 was admitted to the facility on 8/9/16 with diagnoses that included dementia and diabetes. Record review revealed a physician's order, dated 8/9/16, for R89's blood sugar levels to be checked twice a day and to call the physician if less than 65 or greater than 250. Review of the 3/17 eMAR revealed that R89's blood sugar was greater than 250 as follows: 3/13/17 6:00 AM blood sugar =294; 3/13/17 4:30 PM blood sugar = 266; 3/17/17 4:30 PM blood sugar = 308; 3/19/17 4:30 PM blood sugar = 306; 3/20/17 4:30 PM blood sugar = 294. Further review of the 3/17 eMAR and 3/17 progress notes lacked evidence that the physician was notified on the above listed five (5) occasions when R89's blood sugar was above 250. The facility failed to ensure R89's physician orders were followed for reporting when blood sugar levels were above 250 on five (5) occasions as listed above. On 3/23/17 at approximately 12:30 PM findings were reviewed with and confirmed by E2 (DON). 1B. Review of R89's clinical record revealed the following:	F 309	4b. DON/Designee will audit daily vital sign report for bowel movements to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 2. 1. R102 was not negatively impacted by this deficient practice. Moisture Associated Skin Dermatitis (MASD) is unrelated to turning and repositioning. Proper interventions were in place for resident s skin condition. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Staff Educator/Designee to in-service nursing staff regarding proper turning and repositioning of resident while in bed. New Hire Competency Checklist for nursing staff amended to include demonstration of proper turning and repositioning of residents while in bed and appropriate time frame for turning and repositioning. 4. DON/Designee will conduct three random resident observations to ensure compliance daily until 100% compliance is	

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F 309	Continued From page 9 8/9/16 - R89 had a standing physician's order to initiate the bowel protocol per the facility's policy. 3/5/17 6:49 AM through 3/10/17 2:15 AM - Review of the BM documentation, as recorded by CNAs each shift, revealed that R89 had no BM for 15 shifts. Although the eMAR revealed that a Dulcolax suppository was given on 3/9/17 at 1:50 AM that was not effective, there was no evidence that a Fleets enema was given as per facility policy. 3/10/17 2:15 AM through 3/14/17 2:25 AM - Review of the BM documentation revealed that R89 had no BM for 12 shifts. There was no evidence that the bowel protocol was initiated. 3/14/17 2:25 AM through 3/19/17 7:12 AM - Review of the BM documentation revealed R89 had no BM for 16 shifts. Although the eMAR revealed that a Dulcolax suppository was given on 3/18/17 at 6:57 and resulted in only a small BM, there was no evidence that a Fleets enema was given as per facility policy. 3/23/17 approximately 12:30 PM - During an interview with E2 (DON) findings were reviewed. E2 confirmed the findings and stated that "somewhat effective" results should not be counted as an adequate BM and the next step of the bowel protocol should have been implemented. E2 also stated on 3/9/17 and 3/18/17 when the Dulcolax suppository was not effective, R89 should have received a Fleets enema. 2. Review of R102's clinical record revealed the following:	F 309	reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 3. 1a. R152 was not negatively impacted by this deficient practice. MD immediately amended insulin order to include hold parameters on the day that the surveyor identified this deficient practice. 1b. R152 was not negatively impacted by this deficient practice. R152 was given suppository with positive results. 2a. All diabetic residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 2b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3a. Staff educator/designee to educate nurses on onset of action of short acting and long acting insulin. MD added hold parameters for R152 when issue was identified by surveyor. 3b. Staff educator/designee to in-service nursing staff on facility s bowel protocol	

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F 309	Continued From page 10 1/26/17-R102 was admitted to the facility following hospitalization from following surgery (ORIF) of a fracture [broken] of the right Patella/knee. 1/26/17 -The facility's overall admission skin assessment stated, "no obvious problem; no reddened area". 1/26/17-Physician's order included the following: Turn and Reposition completed every 2 hours; Weekly skin check once a day on Friday; Skin checks every 2 hours; report any changes to the nurse. 1/27/2017- Nurse's note stated that Resident complained of discomfort at left ischium (lower and back part of the hip bone) area upon skin check. Skin appears intact, no bruising or symptoms of trauma. Resident was educated on turning and offloading buttocks. Resident is obese with right leg brace on. Resident repositioned to right side with pillow support. 1/28/17-A care plan entitled, "Potential for pressure ulcer related to decreased mobility, leg brace to RLE" was initiated. The short term goal stated, "Resident will be free from open areas at pressure points x 90 days". The approaches were: Neuropedic mattress; Pressure risk assessment on admission; Preventative skin measures as ordered; skin checks every 2 hours and prn; turn and reposition every 2 hours and prn; Weekly skin check as ordered. 2/2/17 Admission MDS assessment stated that R102's cognitive skills for Daily Decision Making	F 309	and sequence of interventions and time frames to initiate bowel protocol procedure. 4a. DON/Designee will audit diabetic MAR s to ensure administration compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 4b. DON/Designee will audit PRN Administration Report for Bowel Protocol to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 4. 1. R28 was not negatively impacted by this deficient practice. Bowel Protocol initiated with positive results. 2. All residents have the potential to be affected by this deficient practice. Future	

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F 309	Continued From page 11 were independent-decisions consistent/reasonable. Resident needed extensive assistance of 2 staff for bed mobility, transfer and all other activities of daily living except eating (needed set up only and feed self); occasionally incontinent of bladder and bowel. 2/2/17 Braden Scale assessment was completed and identified R102 as being a high risk for developing pressure ulcer. The assessment also identified the problem related to Friction and Shearing-Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assist. Resident was also bedfast and with limited mobility. The recommended interventions identified related to this assessment were: Turning/repositioning program; Pressure relieving device for chair; Pressure relieving devices for bed; application of ointment/medications; other preventative or protective skin care. 2/3/17 -A care plan entitled "Resident has moisture associated skin dermatitis to sacral and bilateral gluteal regions. This care plan identified that R102 developed MASD. 2/3/17 - Physician's order "Air mattress to bed, check inflation every shift". 2/04/17 - Nurse's note stated, "Open areas on (L) and (R) buttocks with foam dressing in place dry and intact. 2/10/17 - Skin Weekly Wound Assessment	F 309	residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Unit Manager/Designee to audit vital sign report daily and indentify those residents who meet the bowel protocol criteria. Unit Manager/Designee to maintain daily BM List identifying those residents who should have the bowel protocol initiated that day. 4. DON/Designee will audit daily vital sign report for bowel movements to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 5. 1. R185 was not negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. MD ordered parameters are attached to each medication as indicated on the MAR. Staff Educator/Designee to educate nurses regarding holding/administering medications as per MD order. Staff Educator/Pharmacy Consultant to perform	

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F 309	Continued From page 12 identified bilateral gluteal regions measurement of wound area as "scat". for length, width and depth. Wound bed: Epithelialization-deep pink, pearly pink/light purple. Comments: Resident with MASD to Bilateral gluteal regions-scattered areas present. Improved since last assessment on 2/3/17. Will continue with present treatment and monitor. 2/13/17 - Nurse's note stated, "sacrum assessed for opened area measuring 4cm x 1.5 cm x0.1cm., no drainage noted, site cleansed with NSS, Zguard and foam dressing. Bilateral gluteal sites resolving, treatment continues with Zguard and foam dressing ...". 2/17/17 - skin check assessment failed to identify the MASD skin issue. 2/21/17 - Nurse's note stated, " ...Treatment nurse assessed excoriated buttocks. Applied Zguard and covered with foam dressing ...". 2/27/17 - Physician's order for wound treatment-Cleanse sacral and bilateral gluteal regions with NSS, pat dry, apply zinc barrier, cover with foam, change daily. 2/27/17 -Physician's order for PRN wound treatment, Cleanse sacral and bilateral gluteal regions with NSS, pat dry, apply zince barrier, cover with foam, change as needed for soilage/dislodgement. 2/27/17 - Nurse's note stated, "MASD to sacral and bilateral gluteal regions continues to show improvement ...". 3/10/17 - Weekly Skin Assessment observation	F 309	five random medication observations monthly to ensure medication administration compliance. 4. DON/Designee will audit five random resident s cardiac medication administration history to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting.	

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F 309	Continued From page 13 details stated, "continue with open areas to gluteal regions ...". 3/16/17 at 11:25 AM, during dressing change of R102's MASD, the left gluteal open area measured 1.cm x 0.5 cm x 0.1 cm which was a great improvement according to E8 (Treatment nurse). However, a new open area that measured 1 x0.2 cm. was found on the mid bilateral gluteal separation. Treatment applied was Zguard and foam dressing. Review of the electronic CNA Point of Care History documentation on Turn and Reposition completed every 2 hours (Every Shift), the CNAs signs off at the end of the shift attesting to have carried out the Turning and Repositioning every 2 hours. It failed to show an organized/planned the time the patient was turned/repositioned and the position adopted. There was no evidence in the clinical record/care plan that identify this schedule and to monitor and report any skin abnormalities. The facility failed to develop an every 2 hour turning and repositioning program/schedule in all 3 shifts to ensure that R102 was consistently turned and repositioned every 2 hours and monitored, regularly and to assess the Resident's skin condition to prevent the development MASD. This finding was reviewed with E1 (NHA) and E2 (DON) on 3/17/17 at 2:30 PM. 3A. Review of R152's record revealed: R152 was admitted to the facility on 8/31/16 with diagnoses including diabetes and constipation. According to the February and March 2017	F 309		

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F 309	Continued From page 14	F 309		

eMARs, R152 had a physician's order, dated 8/31/16, for Levemir Insulin 20 units to be given daily at bedtime. R152 also had a physician order, dated 8/31/16, to check BS at bedtime. R152's Levemir Insulin was not administered (held) with notes recorded as follows:

- 2/24/17 Insulin was held due to a BS of 98;
- 2/25/17, Insulin was held due to a BS of 91 and
- 3/5/17, Insulin was held due to a BS of 99.

R152's Levimir Insulin was incorrectly held on 2/24/17, 2/25/17, and 3/517 for BS's in the 90's although there were no ordered parameters to hold the Insulin.

Findings were reviewed with E1 (NHA) and E4 (Director of Clinical Services) on 3/22/17 at 10:41 AM. E4 confirmed findings. Following the interview, on 3/22/17 at 10:59 AM, E2 (DON) gave the surveyor a copy of a new physician's order, dated 3/22/17 and timed 10:51 AM, to "Hold Levemir if blood sugar less than 110."

3B. According to the February 2017 eMAR, R152 had physician's orders, dated 8/31/16 for MOM to be given by mouth daily as needed for no bm for 3 days or 9 shifts and for a Dulcolax suppository to be given rectally daily as needed if prior laxatives (MOM) were not effective.

R152 received a Dulcolax suppository on 2/26/17 at 6 AM.

A progress note by E11 (RN), dated 2/26/17 and timed 7:17 AM, stated, "(Dulcolax) Suppository given this morning. Last noted BM 2/20/17...".

Review of R152's bm records indicated that

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F 309	Continued From page 15 R152's last bm was on 2/24/17, not 2/20/17. E11 administered a Dulcolax suppository to R152 when it was not indicated as it was only 2 days since her last bm. Additionally, if R152 had exceeded 3 days or 9 shifts without a bm, the physician order was for MOM to be given first and a Dulcolax suppository would then be given if the MOM was not effective. Findings were reviewed with E1 (NHA) and E4 (Director of Clinical Services) on 3/22/17 at 10:41 AM. E4 confirmed the findings. 4. Review of R28's clinical record revealed the following: 2/1/17 - R28 had a standing physician's order to initiate the bowel protocol per the facility's policy. 2/15/17 through 2/18/17 - Review of the BM documentation, as recorded by CNAs each shift, revealed that R28 had no BM for 12 shifts. 2/15/17 through 2/18/17 - Review of R28's February 2017 eMAR revealed a lack of evidence that the facility's Bowel Protocol was initiated after R28 went 12 shifts with no BM. 3/23/17 at 1:41 PM - During an interview, E2 (DON) reviewed R28's clinical record and confirmed the finding. The facility failed to follow a standing physician's order to initiate the Bowel Protocol when R28 went 12 shifts, from 2/15/17 through 2/18/17, with no BM. 3/23/17 at 3:30 PM - Finding was reviewed during the Exit Conference with E2 and E3 (ADON). 5. Review of R185's clinical record revealed the	F 309		

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F 309	Continued From page 16 following: 11/16/16 - R185 had a physician order for Metoprolol, an anti-hypertensive medication, two times a day with parameters to hold the medication if her SBP was less than 110 or her heart rate was less than 55. Review of the February 2017 eMAR revealed that R185's Metoprolol was not held according to the physician's ordered parameters: - 2/2/17 at 8 PM, heart rate was 50; - 2/8/17 at 8 AM, SBP was 101; - 2/10/17 at 8 PM, heart rate was 50; - 2/13/17 at 8 AM, SBP was 107 and heart rate was 50; - 2/14/17 at 8 AM, SBP was 108; - 2/15/17 at 8 AM, heart rate was 50; - 2/18/17 at 8 AM, heart rate was 50; - 2/23/17 at 8 AM, SBP was 108. Review of March 1 - 20, 2017 eMAR revealed that R185's Metoprolol was not held according to the physician ordered parameters: - 3/5/17 at 8 AM, SBP was 107 and heart rate was 53; - 3/9/17 at 8 PM, SBP was 102 and heart rate was 51; - 3/15/17 at 8 AM, heart rate was 50. 3/22/17 at 1:56 PM - During an interview with E5 (RN/UM), findings were reviewed and confirmed. The facility failed to follow the physician's orders to hold R185's Metoprolol when her SBP was less than 110 or her heart rate was less than 55 on 8 occasions in February 2017 and 3 times from March 1 - 20, 2017. 3/23/17 at 3:30 PM - Findings were reviewed	F 309		

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F 309	Continued From page 17 during the Exit Conference with E2 (DON) and E3 (ADON).	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of other documents as indicated, it was determined that for two (R102 and R196) out of 23 stage 2 sampled residents, the facility failed to provide care and services to prevent pressure ulcer from developing and failed to thoroughly assess a pressure ulcer. For R102, the facility failed to ensure that R102, who entered the facility without a pressure ulcer, and was assessed as a high risk for developing pressure ulcer, did not develop a pressure ulcer unless the individual's clinical condition demonstrates that they were unavoidable. R102 was admitted in the facility post ORIF (Open	F 314	F314 Treatment/Services to Prevent/Heal Pressure Sores 1. 1. R102 was not negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Staff Educator/Designee to in-service nursing staff regarding proper offloading of heels for residents while in bed. New	6/5/17

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F 314	Continued From page 18 Reduction Internal Fixation) surgery of the right knee with a physician's order to offload heels while in bed. The facility failed to: ensure that R102's bilateral heels was offloaded consistent with professional standard of practice; failed to monitor/identify an area of pressure until it presented as a suspected deep tissue injury (sDTI). For R196, the facility failed to have a thorough and accurate admission nursing assessment with regard to R196's skin and thorough, accurate and timely weekly skin checks related to R196's R heel DTI. Findings include: The facility's "Pressure Ulcer Prevention" policy revision date March 13, 2017, states: " ...To identify residents at risk for skin breakdown and develop and ongoing plan of care for prevention, recognition and treatment of pressure ulcers". Procedure: " ...Residents will have a plan of care developed and updated as needed; Interventions implemented are added to the resident's plan of care; Interventions for residents may include, but are not limited to: ...Offloading heels while in bed ...". The International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Clinical Practice Guideline, second edition published 2014, Pressure Ulcer Classification System identifies six (6) categories/stages. One of those categories/stages are:-"Suspected Deep Tissue Injury (sDTI): Depth Unknown-purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue ...Pressure Ulcer Assessment	F 314	Hire Competency Checklist for nursing staff amended to include demonstration of proper offloading of heels for residents while in bed. 4. DON/Designee will conduct three random resident observations to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. 2. 1. R196 was not negatively by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Staff Educator/Designee to educate nurses on thorough skin assessment upon admission and documentation of findings. Education to also be provided regarding thorough and accurate weekly skin checks to include all skin issues, both pre-existing and new. 4. DON/Designee to audit five random skin checks to ensure accurate nursing documentation and compliance with facility policy daily until 100% compliance is reached over three consecutive days.	

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F 314	Continued From page 19 ...Repositioning to Prevent and Treat heel Pressure Ulcers ...The posterior prominence of the heel sustains intense pressure, even when a pressure redistribution surface is used. General Recommendations 1. Inspect the skin of the heels regularly ...Repositioning for Preventing Heel Pressure Ulcers 1. Ensure that the heels are free of the surface of the bed ... Ideally, heels should be free of all pressure- a state sometimes called 'floating heels' ...Continue to reposition individuals placed on a pressure redistribution support surface ...". 1. Review of R102's clinical record revealed the following: 1/26/17 - R102 was admitted to the facility following hospitalization for surgery (ORIF) of a displaced fracture of the right knee. Facility overall admission skin assessment stated, "no obvious problem; no reddened area". 1/26/17- Physician's Order stated, "Off Load Heels when in bed every shift, night, day and evening". 1/27/17 Nurse's note additional data stated, Resident is obese with right leg brace. 1/28/17- R102's care plan entitled, "Potential for pressure ulcer related to decreased mobility, leg brace (Knee immobilizer)to RLE (right lower extremity)" was initiated. Care Plan's Short Term goals-Resident will be free from open areas at pressure points x 90 days. The approaches were: Neuropedic mattress;	F 314	DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting.	

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F 314	Continued From page 20 Pressure risk assessment on admission; Preventative skin measures as ordered; skin checks q 2 hours and prn; turn and reposition q 2 hours and prn; Weekly skin check as ordered. The approaches did not identify to offload heels when in bed every shift, night, day and evening as per physician's order and plan of care. 1/30/17 Nurse Practitioner Progress note stated, "no identified skin issue". 2/2/17 Admission MDS assessment stated that R102's cognitive skills for Daily Decision Making were independent-decisions consistent/reasonable. Resident needed extensive assistance of 2 staff for bed mobility, transfer and all other activities of daily living except eating (needed set up only and feed self). 2/2/17 Braden Scale assessment was completed and identified R102 as being a high risk for developing pressure ulcer. 2/18/17 nurse's note stated, "Darkened heels noted bilaterally. Offloading in place and skin prep". Bariatric air mattress ordered. To arrive in 4 hours". 2/18/17 Physician's treatment order was to cleanse right heel with NSS (Normal Saline Solution), pat dry, apply skin prep daily once a day; Cleanse left heel with NSS, pat dry, apply skin prep once a day. Review of the electronic documentation of Point Care History completed by CNA's, for Offloading heels while in bed every shift, from 1/26/17 through 2/17/17 revealed R102's heels were off loaded. However, despite the care plan	F 314		

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F 314	Continued From page 21 intervention to inspect the skin every 2 hours and Weekly Skin assessment, there was no documentation and or record of a weekly skin assessment found in the clinical record that skin was inspected every 2 hours or was assessed prior to 2/18/17 until the bilateral heels were identified as sDTI. 2/21/17-A care Plan entitled, "Potential for complications r/t Non-compliance with heel offloading"' was initiated. The approaches were: Educate resident on importance of compliance with Doctor's orders; Treatment administered as order". Review of R102's progress notes, ETARs and CNA's Point Care History documentation between 1/26/17 and 2/17/17 lack documentation that R102 was non-compliant with offloading of the heels. 2/22/17-Weekly Wound Assessment (Right Heel) completed by E8 (LPN) stated, current visual stage, suspected deep tissue injury- ...colored area related to unrelieved pressure, nonblanchable; 4cm length x 5 cm width x depth UTD; no reddened area; wound bed eschar-dark in color; treatment-skin prep. 2/24/17 - Weekly Skin Check completed by E9 (LPN) stated, skin issues: bilateral darkened heels. 2/28/17 - Weekly Wound Assessment of the left heel completed by E8 stated, current visual stage, suspected deep tissue injury, colored area related to unrelieved pressure, nonblanchable; 4 cm length x 6 cm width x depth UTD, wound bed	F 314		

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F 314	Continued From page 22 eschar-dark in color; treatment-skin prep. 2/28/17 - Weekly Wound Assessment of the right heel by E8 stated, current visual stage, suspected deep tissue injury, ...3.5 cm in length x 4.6 cm width, wound bed eschar-dark in color, no reddened area, no drainage noted; treatment-skin prep. 3/7/17 - Weekly Wound Assessment of bilateral heels completed by E8 stated, current visual stage-suspected deep tissue injury ...3 cm length x 4 cm width, wound bed eschar-dark in color; peri-wound healthy-normal skin, no drainage, pain or odor. Area cleansed with soap and water, skin prep and A/D to dry skin areas. 3/14/17 - Nurse's Progress notes stated, DTIs to bilateral heels are now resolved. Treatment to remain in place for preventative care. 3/16/17 at 8:40 AM observation with another surveyor also present noted R102 to be in bed, lying on his back with head of bed elevated while shaving his beard with an electric shaver. One soft pillow was used to off load bilateral heels. Both heels were resting on the surface of the bed instead of being free and off the surface of the bed. 3/16/17 at 10:40 AM-Surveyor observed that R102's heels position did not change. Both heels were resting on the surface of the bed instead of being free and off the surface of the bed mattress. 3/17/17 at 1:42 PM-During an interview with R102's wife, she stated that on 2/7/17 she attended a care plan meeting and the turning and	F 314		

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F 314	Continued From page 23 positioning every 2 hours was discussed. When questioned if the offloading of the heels was discussed with her, she stated it was not. During the interview, she stated that during her visit, she saw Resident's feet flat in bed and was not elevated on a pillow. On 2/18/17, when she visited, she observed dark spots on R102's bilateral heels. She stated that staff was not aware. She told E6 (RN) and E6 took immediate action to offload both heels. 3/17/17 at 3:10 PM-Surveyor observed that a pillow was wrapped around R102's right leg that had the immobilizer and the heel was resting on the surface of the bed instead of being offloaded. One pillow was placed under the left lower part of his leg, however, the heel was resting on the surface of the bed mattress, too. E7 (RN) witnessed this finding and confirmed that the offloading procedure was not acceptable. At 3:30 PM-This observation was brought to the attention of E2 (DON). The facility failed to ensure that R102's heels are free of the surface of the bed/free of all pressure-a state sometimes called 'floating heels' to prevent the development of bilateral heels pressure ulcer; were inspected regularly in accordance with the plan of care until it presented as a Suspected Deep Tissue Injury (sDTI) after approximately 3 weeks from R102's admission to the facility. 3/17/17 at 2:30 PM-findings were reviewed with E1 (NHA) and E2 (DON). 2. Review of R196's record revealed:	F 314		

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F 314	Continued From page 24 Review of a facility policy entitled Pressure Ulcer Prevention", last revised on 3/13/17, stated, "...Purpose: To identify residents at risk for skin breakdown and develop and (sic) ongoing plan of care for prevention, recognition and treatment of pressure ulcers...Upon admission to the facility and weekly thereafter, a skin check is completed and entered in the resident's medical record...". R196 was admitted to the facility on 12/19/16 for short-term rehabilitation post-hospitalization after a fall at home and with other medical problems. Review of R196's Admission Assessment (completed by nurses), dated 12/19/16, listed skin issues including a reddened area on the sacrum and bruises on the legs. Review of an event report, dated 12/20/16 and timed 2:39 PM, stated that R196 had a right heel suspected DTI- purple or maroon colored area related to unrelieved pressure 2.5 x 2.5 (length by width) cm in size and a treatment was ordered. A post admission skin check, dated 12/20/16 and timed 9:13 AM, listed bruising to hips, groin and R arm as well as scabs to the left shin. On 12/21/16, E12 (wound specialist NP) from a contracted wound company evaluated R196's sacral, buttocks and surrounding area and there were no current wounds. The heels were also examined and an unstageable PU, 1.0 x 1.0 cm, non-blanchable, with redness/maroon discoloration was noted to the back of the R heel due to DTI. The following skin checks revealed: - 12/23/16 bruises on L groin and R hip and	F 314		

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F 314	Continued From page 25 redness to sacral area; - 12/30/16 bruising to inner thighs, blanchable redness to heels with skin prep in use and blanchable redness to sacrum; - 1/6/17 skin check not done, although signed for on eTAR; - 1/13/17 no skin issues and - 1/20/17 skin check not done, although signed for on eTAR. E12 evaluated R196's R heel wound weekly which continued to be unstageable due to DTI. On 1/25/17, E12 stated the R heel PU was resolved and she would follow up as needed. R196 was discharged on 1/30/17. The facility failed to have a thorough and accurate admission nursing assessment with regard to R196's skin and thorough, accurate and timely weekly skin checks related to R196's R heel DTI. Findings were reviewed with E4 (Director of Clinical Services) on 3/22/17 at 1:40 PM and E4 stated that he wanted to discuss findings with E2 (DON). Findings were confirmed by E4 on 3/23/17 at 2:30 PM and E2 provided the event report dated 12/20/16 in which she identified the unstageable PU to R196's R heel due to DTI and requested wound care to follow up.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		6/5/17

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F 323	Continued From page 26 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to minimize accident hazards for 3 rooms (Rooms 170, 172, and 177) out of 34 rooms. Findings include: The following was observed on 3/22/17 from 10:00 AM to 10:35 AM during the Stage 2 environmental tour: Room 170 - The bedside commode in place over the toilet in the bathroom rail on the left side was loose; Room 172	F 323	F323 Free of Accident Hazards/Supervision/Devices 1. No resident was affected by this deficient practice. Loose hand rails identified by surveyor were tightened immediately by Maintenance Director. Drainage bag with tubing were discarded immediately. Safety bag was sanitized. 2. All residents with hand rails have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3.	

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F 323	Continued From page 27 - The rails on the sides of the toilet were loose; Room 177 - There were 2 drainage bags with colostomy tubing hanging over the safety bar in the bathroom, at least one had an open connector that was not covered. Findings were reviewed and confirmed with E10 (FMD) on 3/22/17 at approximately 10:35 AM. Findings were reviewed with E2 (DON) and E3 (ADON) on 3/24/17 at approximately 3:30 PM.	F 323	3. Maintenance Director/Designee to perform routine room assessments to include routine inspection of loose hand rails, both wall mounted and resident equipment. Each room will be fully inspected no less than one time per month. Staff Educator/Designee to educate nursing staff on proper infection control practices and proper storage and handling of contaminated resident care items. 4. Maintenance Director/Designee will conduct three random room inspections per day to ensure compliance daily until 100% compliance is reached over three consecutive days. Maintenance Director/Designee will conduct three random room inspections three times weekly until 100% compliance is met for 3 consecutive audits. Maintenance Director/Designee will conduct three random room inspections weekly until 100% compliance is met over 3 consecutive weeks. Maintenance Director/Designee will conduct three random room inspections in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting. Staff Educator/Designee to conduct Infection Control rounds daily until 100% compliance is reached over three consecutive days. Staff Educator/Designee will conduct Infection Control rounds three times weekly until 100% compliance is met for 3 consecutive audits. Staff Educator/designee will conduct Infection control Rounds weekly	

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F 323	Continued From page 28	F 323	until 100% compliance is met over 3 consecutive weeks. Staff Educator/designee will conduct Infection control rounds in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		6/5/17

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F 329	Continued From page 29 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R148) out of 23 Stage 2 sampled residents, the facility failed to consider and use non-pharmacological interventions prior to administering PRN Ativan, an anti-anxiety medication, for 14 out of 22 times in February 2017 and 8 out of 13 times from March 1-22, 2017. Findings include: Review of R148's clinical record revealed the following: 10/13/16 - R148 had a physician's order for Ativan PRN every 6 hours for anxiety. 11/1/16 - R148 had a physician's order to record the frequency of her anxiety episodes every shift and the following non-pharmacological interventions used and their effectiveness: redirection, 1:1, toilet, gave food, gave fluids, changed position, back rub, allowed resident to express feelings. Review of the February 2017 MAR revealed 14 times R148 was administered Ativan medication for anxiety: 2/1/17 at 2:06 PM and 9:32 PM; 2/5/17 at 6:05 PM; 2/6/17 at 6:02 PM; 2/7/17 at	F 329	F329 1. R148 was not affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Staff Educator/Designee to in-service nursing staff regarding non-pharmacological approaches prior to administration of anti-anxiety medications. In-servicing to be given regarding proper documentation of non-pharmacological interventions attempted. 4. DON/Designee will audit five random resident s PRN anti-anxiety medication administration history to ensure compliance daily until 100% compliance is reached over three consecutive days. DON/Designee will audit three times weekly until 100% compliance is met for 3 consecutive audits. DON/Designee will audit weekly until 100% compliance is met over 3 consecutive weeks. DON/Designee will then audit in one month, if 100% compliance, the deficiency will be	

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F 329	Continued From page 30 1:32 PM; 2/9/17 at 6:21 AM and 5:05 PM; 2/12/17 at 4:09 PM; 2/18/17 at 7:29 PM; 2/19/17 at 8:16 PM; 2/21/17 at 6:37 PM; 2/22/17 at 5:49 AM; 2/23/17 at 4:57 PM: and 2/25/17 at 6:41 PM. Review of the February 2017 Behavior Administration History for R148's anxiety revealed the following number of episodes and the non-pharmacological interventions used: - 2/1/17 during day and evening shifts, no anxiety episodes and/or interventions were recorded; - 2/5/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/6/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/7/17 during day shift, no anxiety episodes and/or interventions were recorded; - 2/9/17 during evening and night shifts, no anxiety episodes and/or interventions were recorded; - 2/12/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/18/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/19/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/21/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/22/17 during night shift, no anxiety episodes and/or interventions were recorded; - 2/23/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 2/25/17 during evening shift, no anxiety episodes and/or interventions were recorded. While the facility medicated R148 with PRN Ativan 14 times for increased anxiety during February 2017, the facility lacked evidence of anxiety episodes and consideration and usage of non-pharmacological interventions.	F 329	considered resolved. Results of audits to be presented and discussed at QA committee meeting.	

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F 329	Continued From page 31 Review of March 1-22, 2017 MAR revealed 8 times R148 was administered Ativan medication for anxiety: 3/6/17 at 5:22 PM; 3/10/17 at 10:38 PM; 3/12/17 at 3:38 PM; 3/13/17 at 6:13 PM; 3/16/17 at 9:36 AM; 3/19/17 at 9:14 AM and 4:16 PM; and 3/22/17 at 12:22 AM. Review of the March 1-22, 2017 Behavior Administration History for R148's anxiety revealed the following number of episodes and non-pharmacological interventions used: - 3/6/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 3/10/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 3/12/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 3/13/17 during evening shift, no anxiety episodes and/or interventions were recorded; - 3/16/17 during day shift, no anxiety episodes and/or interventions were recorded; - 3/19/17 during day and evening shifts, no anxiety episodes and/or interventions were recorded; - 3/22/17 during day shift, no anxiety episodes and/or interventions were recorded. While the facility medicated R148 with PRN Ativan 8 times for increased anxiety during March 1-22, 2017, the facility lacked evidence of anxiety episodes and consideration and usage of non-pharmacological interventions. 3/23/17 at 9:15 AM - Findings were reviewed and confirmed during an interview with E5 (RN/UM). The facility failed to consider and use non-pharmacological interventions prior to administering PRN Ativan for 14 out of 22 times in February 2017 and 8 out of 13 times from March	F 329		

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F 329	Continued From page 32 1-22, 2017. 3/23/17 at 3:30 PM - Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference.	F 329		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		6/5/17

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F 441	Continued From page 33 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 441	F441 Infection Control, Prevent Spread, Linens 1. R109 was not adversely affected by this deficient practice. Food cart was	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 development and transmission of disease and infection. The facility failed to ensure that staff wore appropriate PPE [Personal Protective Equipment] when delivering a meal tray to R109, to wash hands after leaving the room and they failed to prevent staff from potentially contaminating other items. Findings include: Review of the facility policy, last revised on 2/27/17, and entitled Standards and Transmission-based Precautions, stated, "...Purpose: To outline the precautions used to prevent the spread of disease and infection...Isolation is recommended by the Center for Disease Control and Prevention (CDC) to control the spread of some diseases/infections...". The CDC's Frequently Asked Questions About Clostridium difficile (C. diff) for Healthcare Providers, last revised on 3/6/2012, stated, "...How is Clostridium difficile transmitted?...Any surface, device, or material that becomes contaminated with feces may serve as a reservoir for the Clostridium difficile spores...spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item...How can Clostridium difficile infection be prevented in hospitals and other healthcare settings?...Use contact precautions...Use gloves when entering patient's rooms and during patient care. Perform Hand Hygiene after removing gloves...use of soap and water is more efficacious than alcohol based rubs...". Review of R109's clinical record revealed: R109 had a care plan for "Actual Infection- C	F 441	immediately sanitized. E13 was immediately removed from assignment and sent home for remainder of shift. 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action(s) outlined below in #3. 3. Staff Educator/Designee to educate staff on proper isolation precautions and procedures. Visual identifier system in place to alert staff on necessary PPE (Personal Protective Equipment) prior to entering resident s room, specific to organism. 4. Staff educator/designee to conduct Infection Control Rounds daily until 100% compliance is reached over three consecutive days. Staff educator/designee will conduct Infection Control Rounds three times weekly until 100% compliance is met for 3 consecutive audits. Staff educator/designee will conduct Infection Control Rounds weekly until 100% compliance is met over 3 consecutive weeks. Staff educator/designee will conduct Infection Control Rounds in one month, if 100% compliance, the deficiency will be considered resolved. Results of audits to be presented and discussed at QA committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085056	A. BUILDING _____ B. WING _____	03/23/2017

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CADIA REHABILITATION SILVERSIDE	3322 SILVERSIDE ROAD WILMINGTON, DE 19810

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F 441	Continued From page 35 Diff", dated 3/9/17. The following observations were made on 3/13/17; -12:55 PM: E13 (CNA) walked directly into R109's room with a meal tray and did not put on gloves or wash her hands after leaving the room. There was signage on the door to indicate the resident was on contact precautions and an isolation cart beside the door. - 12:56 PM: E13 went directly to the food cart in the hall and pulled out another resident's tray to deliver. E13 was stopped by the surveyor and requested to wash her hands. E13 returned the meal tray to the food cart. -12:57 PM: E13 returned from washing her hands and quickly pulled out the same tray from the food cart, potentially recontaminating her washed hands and then delivered it to a nearby room potentially exposing another resident to a C. diff infection. Findings were reviewed with E1 (NHA) on 3/13/17 at 1:25 PM. E1 stated she would have the food cart and affected areas sanitized right away and she was going to speak with E13.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Silverside

DATE SURVEY COMPLETED: March 23, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint survey was conducted at this facility from March 13, 2017 through March 23, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical record and other facility documentation as indicated. The facility census the first day of the survey was 102. The Stage 2 survey sample was 23.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 23, 2017, F0241, F0279, F0309, F0314, F0323, F0329, F0441	Cross refer to CMS-L survey competed March 23, 2017, F0241, F0279, F0309, F0314, F0323, F0329, F0441.	6/5/17

Provider's Signature Laura L. Dittmer Title NHA Date 6.15.17